MEDICAID

MONTANA MEDICAID CERTIFICATE OF MEDICAL NECESSITY

DURABLE MEDICAL EQUIPMENT (DME) AND SUPPLIES (Rev., May 2007)

HOSPITAL BED

EST .LENGTH OF NEED (# OF MONTHS):_____ 1-99 (99=LIFETIME)

SECTION A

PATIENT NAME, ADDRESS, TELEPHONE NUMBER, DATE OF BIRTH	PHYSICIAN NAME, ADDRESS, TELEPHONE NUMBER
MEDICAID I.D. NUMBER:	NPI NUMBER:

RESIDENCE: (CIRCLE ONE) Home, Nursing Home, Hospital Rehab Unit, Group Home Other:_____

DIAGNOSIS:

PROGNOSIS:

DATE OF LAST EVALUATION BY PHYSICIAN:	PHYSICIANS NAME:

SECTION B

1. Has the patient received a trial in the use of this item:	Y / N
2. Does patient have the physical and mental ability to operate or use the item:	Y / N
3. Can the patient or care-giver be responsible for the maintenance of this device:	Y / N
4. Does the patient require positioning of the body in ways not feasible with an ordinary bed:	Y / N
5. Is elevation of the head at more than 30 degrees required due to congestive heart failure __, chronic pulmonary disease__, or aspiration __:	Y / N
6. Does the patient require traction which can only be attached to a hospital bed:	Y / N
7. Does the patient require a bed height different than a fixed height bed:	Y / N
8. Does the patient require frequent changes in body position and/or have an immediate need for change in body position:	Y / N

9. Is patient (circle one) Room Confined Bed Confined Non-ambulatory Ambulation Impaired Other _____

10. Narrative description of **ALL** items, accessories, sizes and options, etc., to included model numbers in this section: (If additional space is needed, a continued narrative can be attached to this document as long as the pertinent patient and physician information is included at the top of the attachment. Physician's signature must also be included on the attached document).

Y / N ADDITIONAL ATTACHMENTS ARE INCLUDED

I certify that I am the treating physician identified in this form. I certify that the medical necessity information contained in this document and its attachments are true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in this document may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE ____/____/____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

MONTANA
Department of Public Health & Human Services